DOCUMENT RESUME

ED 210 257 SP 019 156

TITLE "Children's Health Care, Parts 1-4." Options in Education Takes Listeners to the Core of the Issues.

INSTITUTION George Washington Univ., Washington, D.C. Inst. for Educational Leadership.; National Public Radio, Washington, D.C.

PUB DATE 81

NOTE 48p.

EDRS PRICE MF01/PC02 Plus Postage.

DESCRIPTORS *Birth; *Child Rearing; Economically Disadvantaged; Health Education; *Medical Services; Moral Values; *Obstetrics; Parent Attitudes; Parenthood Education; *Pregnancy; Preventive Medicine; Retrenchment

ABSTRACT

The scripts of four programs of National Public Radio's Options in Education series are presented. The first program has sequences involving the use of high technology in childbirth. Interviews with doctors and expectant mothers explore the use and availability of electronic monitoring equipment in prenatal care. In the second program, the high technology itself is described through discussions with specialists. Much of the discussion centers on the ethical nature of using technology to save high-risk newborns. The third program concentrates on the health problems of poor children and presents the viewpoints of: (1) a mother of a sick child in a community health center; (2) a pediatrician discussing children's health needs; and (3) a clinic director facing budget cuts. The focus of the fourth program is the care provided in a pediatric emergency room in a public hospital. Clients' use of health services and the economic and social impact of impending financial cutbacks are explored. (FG)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
J. Merrow
NPR
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ED210257

OPTIONS IN EDUCATION

takes listeners to the core of the issues

"Children's Health Care"
Catalogue No. OE-810512-T

A co-production of
National Public Radio
and the Institute for
Educational Leadership of the
George Washington University

SP 019 156

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

©1981 NPR All Rights Reserved

"CHILDREN'S HEALTH CARE, PARTS 1-4"

Table of Contents

Part 1 The first program in this series looks at the use of high technology in childbirth. Electronic fetal monitoring, sonograms, amnioscentesis--are they safe, useful? Do the people who need this technology have access to it? As we spend millions of dollars on high technology, are we turning our back on low technology prenatal care, such as nutrition?

A Baby is Born 1

A Doctor Demonstrates One Type of Electronic Monitoring Equipment 2

One Doctor is Concerned About Using Electronic Monitoring Equipment 4

One Doctor Says the Technology is Important, Not Abused 7

Schorr Describes the Poor Care Many Pregnant Women Receive 8

Continuation of the Birth 9

Part 2 This second part describes the technology of neonatal intensive care units, technology that has made it possible--even routine--to save newborns weighing less than two pounds. As the technology improves, certain ethical questions become urgent: At what point should technology not be used--if, for example, a baby will be severely multiply handicapped if he survives? Do doctors treat all babies equally--that is, the newborns of rich and poor alike? And if a mother wishes to abort a fetus that could be saved, say at 23 or 24 weeks, who decides whether to abort or rescussitate?

Dr. Litman Describes a Baby in the Neonatal Unit Who Weighed Less Than Two Pounds At Birth 11

Tour of a High-Tech Neonatal Intensive Care Unit 12

Merrow Asks About the Danger of the Technology 15

A Pediatrician Discusses the Ethical Questions Raised . 17

Goldsmith Comments on the Ethical Questions 18

Mother of a Newborn in a Neonatal Intensive Care Unit . 18

Part 3 In Part 3, we look at the health problems of poor children, and at the system which is supposed to care for them.

Merrow Talks With a Mother Who Brought
Her Sick Child to a Community Health Center 21

Pediatrician Discusses Children's Health Needs 23

Goldsmith Describes Prenatal Influences
On the Health of Children 25

Clinic Director Discusses the Effect of Budget Cuts . . 26

Weitz Describes the Effects of the Federal Budget Cuts . 29

Part 4 In the final part of the series, we go to the pediataric emergency room of a public hospital, to find out how clierts make use of the health services available to them, and also how they will be affected by impending financial cutbacks.

Patient in Pediatric Emergency Room 33

Triage Nurse Screens Infant, and Explains Why
Patients Use the Emergency Room Routinely 35

Knight Discusses the Quality of the Care
At Charity Hospital 37

Cab Driver Tells Why He Remains an Unmarried Parent . . 38

Goldsmith Describes Another Example 40

Greene Describes the Economic and Social Impact
Of Budget Reductions on Health Care Services 41

Weitz Shares Her Concerns Regarding the Effects
Of the Reagan Budget Cuts on Children's Health Care 42

A BABY IS BORN

Obstetrician: Please listen to the fetal heart tone for me.

Mother: I did already.

Obstetrician: You did already?

Mother: Uh huh. It's fine.

Obstetrician: Is everything all right?

Mother: Yes, everything's fine.

Obstetrician: Very good. So we are all ready, Mina, for you. Are you ready to be a mother again?

Mother: Definitely! (laughter)

Father: Better than the alternative, right?

(laughter)

Obstetrician: Well the alternative is too late at this stage, huh? Take a deep breath, darling, and push--bear down, way, way hard, hard, hard, hard, hard, hard, hard, hard, hard, hard, hard--a little bit more, Mina. Take another deep breath, push, push, push, push, push, push, harder, harder, harder, harder, harder, a little bit more, Mina. Oh, you are doing fantastic, Gerald. Can you take another deep breath, first--push real hard. Good, good, good, good, you are doing a fantastic job.

Mother: Go, go, go, go!

Obstetrician: Give me a little bit more push. Mary Ann, you can help load with the frontal pressure so we'll get this baby out right now. Okay.

Nurse: I'll be pressing on your stomach a little bit.

Obstetrician: Mina, fantastic girl you are. Do you want to watch in the mirror Mina?

Nurse: Look in the mirror--.

Obstetrician: Look at the mirror--it is coming out--fantastic--the cord is around the baby's neck one time, but it is loose so it won't--. Okay, give me one more push, to get the shoulder out. Fantastic! Mina, what would you like, boy or girl?

Mother: It doesn't matter!

Obstetrician: It's a little girl!

(baby cries)

Obstetrician: Baby is a lively baby.

Father: Well, Warren will be happy now!

(baby continues to cry)

Obstetrician: Little lively baby, Nina. Everything is all right. You did very good job!

(laughter)

Mother: Look!

Reinhardt: The feelings of that moment are timeless. But the experience of childbirth has changed. Technology has entered the scene. Within the last twenty years electronic fetal monitoring, sonograms, amnioscentesis have become standard procedure, with many benefits, and some risks. I'm Barbara Reinhardt.

Merrow: I'm John Merrow, for NPR's OPTIONS IN EDUCATION.

A DOCTOR DEMONSTRATES ONE TYPE OF ELECTRONIC FETAL MONITOR

Weingold: All right, let's listen to the baby now. What we have is a--a Doppler Ultra Sound, which is an instrument which, uh, puts a continuous wave of sound into the tissue. And if we focus it, uh, on an area in the baby where the baby's heart is pushing fluid--blood--in through the blood vessels, or if we actually aim it directly at the fetal heart, this wave of sound is interrupted every time the baby's heart beats, and we'll get a sound echo coming back through the machine, uh, amplified in the equipment, which will be a--a noise consistent with the baby's heart rate. It may sound like a gallop, or a thumping; in fact all it is is an interruption of this sound wave, which we are now putting on through the mother's abdomen. Now, let's see if we can locate the baby's--

(heartbeat sound)

Now you can hear that sound's like a gallop, because we're not only getting each heartbeat, we're getting the various sound components of the baby's heart rate contraction. As each little valve in the heart opens and closes we're getting these multiple sounds.

(heartbeats continue)

Now that's the baby's heart rate sound. From the point of view of surveillance of the baby, obviously we're just listening for 30 seconds or so, and that just tells us that the fetal heart, essentially, is there or not. More importantly would be taking this kind of information, recording it over a longer period of time, and looking at the, uh, long-term changes in the heart rate--does the baby's heart rate remain constant; does it increase as the baby moves; does it decrease, and so forth. That's a different form of assessment of the heart rate, and that's some of the technology we can look at in terms of the fetal monitor. But this is an auditory thing, um, it's advantage is that we can hear the baby as early as--when did we first hear the baby move?

Expectant mother: Twelve or 13 weeks.

Weingold: About 12 weeks of pregnancy. Uh, yeah.

Goldfield: Couldn't you do that with a stethoscope?

Weingold: No, you can't hear the fetal heart, uh, with your ears until around five months--20 weeks of pregnancy, at which time, basically, the mother already is aware of movements. So at the time she says, "The baby is now moving," is when you can first hear it. On the other hand, with this equipment one can hear it as early as about the ninth or tenth week of pregnancy, and of course that's extremely useful information in a situation where you're uncertain of the dates of pregnancy, or when the patient is having light bleeding or spotting--you're wondering as to the viability or health of the pregnancy. The ability to hear the baby at that point is tremendously useful.

Goldfield: But this is fairly late in the pregnancy--what month?

Weingold: One week to go.

Expectant mother: One week to go! (laughter)

Goldfield: So why not just use the stethoscope in this case?

Weingold: So that--because she can't hear the stethoscope, and this is for the patient, then, auditory reassurance--she knows the baby is moving, she's comfortable with the baby doing well--but there's something very reassuring about hearing the baby's heart rate. You will notice also, when we show you the fetal monitor, that we keep some sound on. So not only is there a--a--a visual record, but the mother is able to hear that during labor, so that if she doesn't want to look at the monitor, she wants to close her eyes, she has that reassurance of hearing the sound of the baby.

Goldfield: Is that quite accurate? Are you reassured by hearing these sounds?

Expectant mother: Oh yeah. Definitely. When I first heard it, at 13 weeks, it was just amazing. I mean, it was so good to hear it and to know that, you know, it was there and alive and--and it became real for me at that point.

Weingold: Which is not true in the absence of that, because, obviously, all the--the--the symptoms in the first three months are all, in a sense, negative symptoms--you're tired, you're--you're stomach's upset, you're--you have breast soreness, you have disturbances in bladder and bowel function. You know you're pregnant, and in a conceptual sense--not to be a pun!--but in a--in a mental sense you know you're pregnant, but you have no feeling of it. And then to hear the baby, two or three months before you normally would hear it or feel it, is a very positive sign. And I think most patients, uh, have a--have a sense that, when they can first hear it, that the major concerns that they would normally have over miscarriage have evaporated--"I'm--this is a good pregnancy, we're going, and that's a good sign."

Goldfield: Sounds almost like a more psychological benefit that would--.

Weingold: Yes, yes, for the patient--for us, of course, medically it's important that--to--to--validate the viability of a pregnancy early, so that we can begin to look at how far pregnant the patient is. When there are medical problems we can date the pregnancy accurately, and we can also pick up, by this simple method, abnormalities in the baby's heart rate.

Goldfield: Okay, but no problems like that here, right?

Weingold: No, nice healthy. All right, kiddo, so I think you're, uh, you know, on target, uh, not imminent, but on target!

(laughter)

See you next week!

Expectant mother: Okay.

Goldfield: I just--I have a few questions to ask you. You've availed yourself of all of the technology that's around. Did you ever consider that it might be dangerous--did you ever have any fears like that?

Expectant mother: No, not at all. Because it is sound waves. Women have fears of X-rays and things like that, and that's--that's normal, and of course you should always consult with your doctor before X-rays or something like that. But with the sound waves, there's not that danger, you know. It's just using sono, you know, like they do with depth--I don't know, whatever--.

Goldfield: I hear a lot of trust in your voice in technology.

Expectant mother: Mm hmm. I believe what my doctor tells me too, I mean, I work here with him, and I've seen the things that can go wrong, and I know, you know, um, that if there's any way to--to prevent it, this is the way to do it. You know, so many times there's, you know--you just don't know what's going on inside. You can't see, obviously, and--and without being able to have that monitor on that it says, you know, the cord looks--according to this, the cord might be wrapped around him. Let's go in and get the baby, and not worry about it, you know, which you wouldn't maybe be able to see from the outside.

Merrow: Her baby's due in a week. She and her doctor, Alan Weingold of George Washington University, talked with Rebecca Goldfield. That patient's faith that technology will help ensure a healthy delivery may be a bit naive. Not everybody has such trust.

ONE DOCTOR IS CONCERNED ABOUT USING ELECTRONIC MONITORING EQUIPMENT

Banta: The evidence for benefit from electronic fetal monitoring is, uh, very skimpy. The evidence risk is pretty convincing. I mean, there is--there are risks associated with it, so that I think we have to approach the use of this kind of technology--this specific technology--with a lot of--a lot of caution.

Reinhardt: Dr. David Banta works with the Congress's Office of Technology Assessment in Washington, D. C. Banta's primary concern is not with the external fetal monitoring Mrs. Dorito just had, but with the internal kind sometimes used during labor. There, the amniotic membrane must be broken, so that an electrode can be clipped to the fetus's scalp while it's still in the womb. This not only increases the possibility of infection, but also restricts the mother's movements at a time when some say free movement is important.

Merrow: Banta also worries that doctors sometimes misinterpret the monitor's print-out and see problems where none exist. He says the increased rate of Caesarean section--it's more than quadrupled in the last 15 years--is related to the increased use of electronic fetal monitoring. Besides, he says, the technology's safety and effectiveness have not been properly evaluated. Banta estimates that only 10 or 15 percent of women need this monitoring, instead of the 50 percent or more who get it. If everything he says is true, then why have the medical profession and the public accepted the technology, seemingly without question?

Banta: In--in the '50s, which led up to this period, and '60s, our infant mortality was a question of a lot of concern in this country. There had been a steady fall, and then there was a plateau in the fall in the infant mortality rate. The obstetricians were blamed for that in the press and in the professional literature, and--

Goldfield: They were blamed for the leveling off of the--.

Banta: Yes. In other words, if our obstetricians were doing their job, our infant mortality would be better. Well, to me, that's a very unfair charge, but nonetheless, it was something that came up over and over again. So, the obstetricians felt a tremendous pressure to deal with this problem. And this technology came along into this climate, where the--with a general faith in technology, a faith that technology--almost any technology under any circumstances--would be good. It was also a time when careful evaluations weren't done very--very often. Things have really changed since 19--since the 1960s in that regard. So a number of things that might not be repeated today were true of--of the '60s and early '70s.

Then, as the monitor began to come into widespread practice, there were--there were other factors that, uh, that pushed its, uh, spread. One was that since we did have this faith in technology, insurance companies readily paid for it. And so then it--it's in the, uh, financial interest of both the practitioners and the hospitals to provide the technology. It also--assuming that the machine is going to be there for the high-risk, um, there's a tendency to use it on everybody. It has to--has to pay for itself. It shouldn't just sit idle; the staff who is going to use it needs to use it periodically, if not often, to maintain their skill, and so forth. So all the pressures are there to use it, once it's on site. And why not use it? It's paid for, it doesn't cost the patient any--anything. And in this climate of not considering the risk, having the faith in the technology, I think that you

can fully understand why--why people would--would begin to use it.

Then, with the upswing in malpractice in the early '70s, as this became considered to be the standard practice by the obstetric--by the academic obstetricians, it became more--more and more risky for a practicing obstetrician in the community not to use it. And it's been very poignant to me, being involved in malpractice suits, where people with human tragedies--that is, dead babies or, more usually brain-damaged babies, babies with cerebral palsy, mental retardation--have sued their obstetricians. And one of the contentions has been that their obstetrician should have used electronic fetal monitoring.

Goldfield: So some doctors are forced to use the technology they're concerned about; and yet, because of the malpractice suits--.

Banta: Yes, I talked to a doctor from, uh, Pittsburgh, I think, on the telephone, and he, um, he told me how he was determined he was not going to use monitoring routinely, but on the other hand, the malpractice risk was tremendous. So he said that he--he goes through and--a whole educational thing with every patient, and he asks them to sign a release that they understand that he does not use electronic monitoring, and that they take responsibility. He said, "I know that that's not a full protection. But I really do not want to use this--this technology." So I think the pressure on the obstetrician, right now, is very, uh, serious. I still--I still think that we have, uh, much too much of an optimistic feeling about technology being able to--to solve these problems. I think of technology as no more than an aid to, uh, trying to patch us up and keep us in one piece. But it's not the cure-all that the--the general public seems to think it is. I really reject the idea that it should be imposed on the 40 percent who don't want it, or who--who find it stressful. I think in those cases it should not be done.

Goldfield: Is that generally the case? Is it generally imposed on people who wish not to have it?

Banta: Oh yes. Uh, you know, generally is a--is a hard word. But, uh, many hospitals do it as a routine, or more or less as a routine. Many obstetricians do it as a routine. Hospitals, uh, may not admit a--a woman--obstetricians may not take a woman into their practice if she doesn't want to be monitored electronically. So I think there's a--there's quite a lot of coersion going on. There was a lawyer who worked for Ralph Nader whose wife became pregnant and went to--when she was in labor they went to a hospital here in the District--which I won't name, for obvious reasons. The hospital, uh, presented the permission form for her to be admitted to the hospital, and, uh, they wrote on the permission form, "excluding electronic fetal monitoring." The hospital informed them that--that they did routine monitoring on every patient in that hospital. Um, at that--at that point the lawyer said that they were going to admit his wife, and they were not going to do monitoring, and if they didn't do that, he was going to sue them, and he assured them he was going to win. After a conference of about five minutes, the hospital changed its policy, and to

this day does allow patient choice. I'm sure that there are still many subtle pressures on women to accept the monitoring. But at least the formal policy has now been changed in that particular hospital. I thought that was an interesting way that consumers could, uh, force--of course, everybody isn't a lawyer who works for Ralph Nader (laughter), which is another kind of problem.

Reinhardt: David Banta, Office of Technology Assessment, Washington, D. C., talking with Rebecca Goldfield. Obstetricians we spoke with deny using electronic fetal monitoring excessively. They say the risk of infection is less than the chance of a complicated or even fatal delivery. They resent the charge that the monitoring they do has resulted in more Caesarean sections, and say that the rise in the C-section rate has many causes. Dr. Corine de Cholnoky:

ONE DOCTOR SAYS THE TECHNOLOGY IS IMPORTANT, NOT ABUSED

de Cholnoky: If you want my opinion on why we're doing more Caesarean sections--after having done 11 Caesarean sections in a 24-hour period last week!--I think it's that babies are bigger today than they ever were before.

Reinhardt: Is that right? But aren't mothers bigger too?

de Cholnoky: Uh, not necessarily. I mean, I wonder myself why we're doing so many more Caesarean sections than reportedly we have been. I don't think monitoring is at fault. Most of them we do--and believe me, I've done a lot of soul searching about this, because I as a woman wouldn't necessarily want to have one myself if I were in labor--most of the ones we do here, there's no question that they're indicated. We just seem to be having a lot of big babies whose heads don't fit through the normal, uh, pelvis in any normal kind of labor pattern. I mean, if you let a woman labor for three days, she may end up delivering a terribly depressed fetus vaginally, and that's obviously not the object of our prenatal care and monitoring during labor. We want to give the healthiest baby to a healthy mother.

Reinhardt: Of the 11 that you did a C-section on in that 24-hour period last week--most of them were that the baby was just too big to come through in a--in a reasonable amount of time?

de Cholnoky: At least half of them were that. And others were for malpresentatons and maternal herpes infections, and other medical problems not necessarily related to the labor process itself.

Reinhardt: There are also--there are some people who suggest that these machines--I mean, the more machines we have--are really more for the doctors than they are for the patients. That it--it's kind of, uh, an ego-fanning thing to have all these machines around--it makes it--makes it seem more like a real, uh, science than childbirth, which is a natural thing.

de Cholnoky: Yes, childbirth is a natural thing. But in the

past, during this natural thing, women were in labor for days, died, um, had their perineums torn to pieces because there wasn't anyone to attend to the tears--sewing them up afterwards--bled to death, died of infection--all those were natural things. These are the natural things that we're trying to prevent today by doing all of this. I think part of the problem, I'd say, is the way people see doctors as being "establishment," anti natural things, and being very materialistic. I--basically, I don't think that's the case at all. I think doctors start off as very idealistic people, and, uh, they want to do good. And that's still the underlying motivation, I think, for most doctors, and so the reasons behind most of these things are precisely that--to do good. Now, uh, in the process it may turn out that some people are alienated by our technology, but, uh, a lot would happen in terms of solving these feelings between doctors and patients if people just communicated a little bit better.

Merrow: Our question, whether all those who receive this high technology need it, has a flip side. Do those who need it get it--high-risk mothers who are poor, or very young, or poorly educated? There are documented stories of women who can't pay being turned away from hospitals and delivering in the parking lot, to the detriment of the baby.

Reinhardt: More typically, these women are cared for when they come in with a complicated labor. What poor women usually don't get is the prenatal care that might have prevented the need for high tech later--services like early screening for high-risk mothers, education about the risk to the fetus of smoking and drinking, and about the importance of eating well. Lisbeth Schorr chaired a federally-funded study on child health.

SCHORR DESCRIBES THE POOR CARE MANY PREGNANT WOMEN RECEIVE

Schorr: If, um, a woman in Chicago finds herself pregnant, and the only place where she can get free or low-cost care is Cook County Hospital, which is two hours away by public transportation, and in order to get it she has to bundle up her other kids, take them all with her, get there at 8 o'clock in the morning, wait for hours and hours and hours because they don't have an appointment system, and then when she's seen, she's seen in a place--in a cubicle where there's no privacy, where, uh, people come by in the corridors, she's up with her, uh, with her legs up on the stirrups, and it's as if--it's as if she weren't a human being at all who--who needed to be treated with--with respect and dignity.

Reinhardt: And this is true?

Schorr: Now this--this--this is what happens in many cases. And the, uh, the--and it is alleged that--well, your health--prenatal care is available. The fact that people tend not to take advantage of that availability until they get into some sort of trouble, or until it is very late in their pregnancy, isn't--not so hard to understand. The fact is that when you offer the services in a more accessible and more acceptable way, people do use them, and the outcome is better. If we can organize ourselves to

provide, uh, neonatal intensive care--which is the most extraordinarily complex and exquisitely elegant, uh, organization of resources and of scientific knowledge and of the brilliant and ingenious American mind--if we can organize all that, at a cost--an average cost of something like between $20,000 and $40,000 per baby, why is it that we can't organize accessible prenatal care from nurse-midwives, uh, working with obstetricians, um, lay people--lay counselors can be trained to help with that, to do outreach work, and so on. I don't think we have to choose between, uh, high-technology care and low-technology care. What we can do is make sure that the inexpensive, preventive interventions are available to everybody who needs them. As a result of that, there will be less of a need for high-technology, very expensive neonatal intensive care.

I'm not advocating that we cut back on the availability of those miraculous things that we now can make available to save babies. I don't think anybody who is concerned about making prenatal care more accessible would want to do that. We, um--what we need to do is work at both ends of the spectrum, um, and we need to recognize that medicine--that good health care--requires more than narrow medical interventions. Our ability to recognize a high-risk pregnancy, uh, which we now have--to intervene with a woman who is diabetic, hypertensive, or whatever it is that makes the pregnancy high-risk--is no good if we can't find ways to reach that woman in the first trimester of her pregnancy, when the intervention will be the most effective.

Merrow: Lisbeth Schorr, Chairman of the Select Panel for the Promotion of Child Health.

CONTINUATION OF THE BIRTH

(baby is crying)

Obstetrician: (unintelligible) What do you have for her name?

Mother: Meagan.

Reinhardt: How do you spell it?

Mother: Well, we--

Father: We haven't decided yet how it's quite going to be spelled.

Mother: We were debating that in the labor room!

Reinhardt: How did you choose the name?

Mother: Well, our other little girl's name is Lauren, and she was the one who came up with the name of Meagan.

Reinhardt: She was? You should have asked her how to spell it!

Mother: Maybe we will! (laughter)

Nurse: I'll wrap her up and bring her over to you, okay? We also have these new little caps to put on the baby's head, because that's where the lose most of their heat. Just--it goes on top of their head, there.

Goldfield: This is just standard procedure, huh?

Nurse: Mm hmm. Yep! Sure is! (laughter)

Mother: Oh, she's cute!

Father: Oh, I don't know about that! (laughter)

Mother: That's some hat you've got! (laughter)

Nurse: That's an original!

Mother: I see! Oh my heavens! Good gracious! I think she looks like her daddy.

Father: Yeah, I can--I can tell, uh, it's an ugly face! (laughter)

Mother: Hello! Hello, sweetie! Are you just looking all around, hmm? Hi! You need to wash your face! Yes, you need to wash your face!

Merrow: Next, using technology to save newborns weighing only one and a half or two pounds.

Reinhardt: Copies of this four-part series on Children's Health Care are available. The cassette recordings cost $14.00; the printed transcript costs $6.00. Here's how to order. Call this toll-free number: 800 253-0808.

Merrow: If you live in Michigan, call 616 471-3402.

Reinhardt: If you'd like to write to us directly, our address is National Public Radio--Education, Washington, D. C. 20036.

Merrow: OPTIONS IN EDUCATION is a co-production of National Public Radio and the Institute for Educational Leadership of the George Washington University. Support for the series is provided by the National Institute of Education and the Corporation for Public Broadcasting.

Reinhardt: John Merrow produces OPTIONS IN EDUCATION. Rebecca Goldfield is our associate producer. Our engineers are Greg Hedgepath and Marty Kurcias. I'm Barbara Reinhardt.

Merrow: I'm John Merrow, and this is NPR--National Public Radio.

DR. LITMAN DESCRIBES A BABY IN THE NEONATAL UNIT WHO WEIGHED LESS THAN TWO POUNDS AT BIRTH

Litman: This is a little boy who was somewhere between 24 and 25 weeks gestation, which, uh, is right at the border of viability. We normally consider babies about 28 weeks to have a very good chance. Um, under 25 weeks they have almost no chance, and this cut-off--somewhere around 26, 27 weeks--for having decent statistics. At about 28 weeks when they hit about 1,000 grams, they have probably a 50-50 per chance--percent chance of making it.

Reinhardt: So this baby weighed under two pounds when he was born?

Litman: Yes, one pound, nine ounces--700 grams, and has lost, um, about 100 grams since then. And as the mother went into premature labor, and the baby was delivered, it required being intubated, which means putting a tube in the trachea so that we can, with the machine, breathe for the baby, or ventilate the baby. The baby also has various IVs, a catheter in the umbilical artery was placed, and that's the way that we keep, um, measurements of the blood gases, and measurements of the blood pressure continuously done on the babies. But you could see how tiny the baby is.

Reinhardt: I know you can't guess, but I'm going to ask you anyway, do you have any idea whether the baby will make it?

Litman: Many of these babies die. About a third of them die within the first 36 hours, and then another third of them die sometime during their hospitalization, often many weeks out. It's a long, long battle.

Merrow: Dr. Ferne Litman, and everyone else in that intensive care unit, is going to extraordinary lengths to save that baby. He was born nearly four months early at Fairfax Hospital in Virginia. In the last twenty years, the chances of such a tiny infant's living to become a healthy baby have increased twentyfold. New technology and new understanding of the newborn have made the miraculous commonplace. Neonatal intensive care units nearly duplicate the womb, and enable the fragile infant, sometimes weighing less than two pounds, to breathe, take in nourishment, and continue developing. Today these babies do well--routinely, but expensively--it can cost $100,000 to keep a one and a half- or two-pound baby alive.

Reinhardt: The very existence of this life-saving technology raises troubling questions--do all who need it get it? At what point do heroic measures become counter productive? How often do we save a baby nature would have aborted? And as younger and younger fetuses can survive, are we reaching a time when we save one fetus and abort another--both the same age, and at the same stage of development? I'm Barbara Reinhardt.

Merrow: I'm John Merrow, for NPR's OPTIONS IN EDUCATION. Let's begin with a tour of a high-tech neonatal intensive care unit. Our guide is Dr. Jay Goldsmith, head of Pediatrics at Ochsner Clinic, a private hospital in New Orleans.

TOUR OF A HIGH-TECH NEO-NATAL INTENSIVE CARE UNIT

Goldsmith: This is a baby that's being cared for in an open, what we call radiant warmer. Uh, the baby's crib is open, but he couldn't maintain his own heat or temperature in that, uh, crib, unless there were a radiant warmer above him to give him radiant heat down. And there is a probe attached to his skin with a sensor--very much like the thermostat in your house--and if the skin temperature gets too high, it lowers the heat; and if it gets too low, it raises the heat. So it keeps him, uh, at the appropriate neutral temperature.

Merrow: Is that a respirator, that little tube that--that seems to be right at the edge of the baby's mouth?

Goldsmith: That's correct. There's a tube going into the mouth, down into the lungs, and leading out to another pair of tubes that go to a machine that's over on the left--the blue machine that's on the left. And that machine is a positive-pressure ventilator. And at a prescribed number of times in a minute, it pushes air into--and oxygen--into his lungs, and the whole idea is that that machine is supposed to be a temporary device, and that is, it replaces the function of the lungs, the--or at least of the musculature surrounding the lungs, the diaphragm and the muscles that help open and close your lungs--it replaces that until the baby is old enough or strong enough to do that himself. And so that's what an artificial, or ventilator or a respirator does. Now this baby also has had--has been premature, and has had the most common of the diseases of prematurity--hyaline membrane disease. As you may remember, Patrick Bouvier Kennedy, Jacqueline Kennedy's son, had this disease in 1963.

Merrow: At that point I think 70 percent of the kids with that disease died.

Goldsmith: That's correct. And we know a lot more about that disease now, uh, there has been a lot of research to the point that today--within the last couple of months, a Japanese researcher has come up with something to inject into the lungs to replace--or to become the oil of the lungs. The--the problem that--with this disease is that the oil of the lungs is missing--it's called surface active material. It's just--in premature babies it just hasn't been formed yet.

Merrow: So therefore the lungs can't go in and out, up and down.

Goldsmith: That's right. They can't open and close, very much like a piston in your car--they can't open and close, and we do that artificially with a respirator, but we have problems with that on occasions--we can--we can have all sorts of problems, without getting too technical. Now a Japanese investigator has come up with a substance which he can inject into the lungs, through the tube, and that replaces the normal surfactant of the baby. And this may be the answer to hyaline membrane disease. Everybody is very excited about it; however this is still undergoing clinical trials--it's not released for use yet commercially, or in the medical profession, and just like

anything else, the Drug Administration is going to take a very long and hard look at it, and it may be several years before we have this available to us.

Merrow: Meantime, you are saving most of the babies anyway who have this disease.

Goldsmith: We're saving 90 percent of them now in most intensive care centers.

Merrow: How old his he--she?

Goldsmith: This baby's 31 days old--and it's a he!

Merrow: And--and how small was he 31 days ago?

Goldsmith: He was about two pounds--he's grown quite a bit. And we have been now trying to wean him off the respirator--not because he has severe lung disease anymore, he does have some chronic lung disease actually caused by the respirator itself--the treatment actually causes scarring, uh, of the lung. It's as if I took--and this baby was getting about 30 breaths per minute--if I were to hit you on the arm 30 times a minute, every minute of every hour, for several days, you'd get a bad bruise and some scarring. And that's exactly what's happened to this baby. So he has some scarring of his lung--the medical name is bronchal pulmonary displeasia, but that's--the--but his biggest problem is that he has had a--bleeding into the central part of his brain, called the ventricals, and, uh, we're waiting for that to resolve and supporting his respirations until that time. And what happens to his brain after that, whether it will resolve without harm for the rest of his life or whether he'll have certain problems, remains to be seen. But--.

Merrow: You don't know whether he's significantly retarded or retarded at all?

Goldsmith: No, but a significant portion of these children are retarded, depending upon the gradation of their hemorrhage--we grade the hemorrhage as grade one, which is a very minimal hemorrhage, to a grade four, and the ones with a grade four obviously have a much more significant chance of being retarded than a grade one. And very honestly, I don't remember exactly what the grade of this baby's hemorrhage was, I think it was a two or a three, and we're waiting to see that resolve. The parents are well aware of this, and this--we come again to one of those problems where the relationship with the parents means so much. Because they must trust in us, and we need to meet and talk about this for the future of this child.

Here is another small baby who is again about 1,000 grams. He's seven days old. He has the tube still in his, uh, umbilicas, or belly button, that allows us to sample blood, and also on the monitor there you can see the third line of the--the third line down is his blood pressure, beat by beat--that's exactly what his blood pressure looks like, his blood pressure curve. We monitor those things, and again, he's on the respirator; he has hyaline membrane disease, and possibly an infection. And premature babies are very susceptable to infection. They do not have the

same immunity or defenses against infection that you and I--or even a term baby--would have.

Merrow: Infection of?

Goldsmith: Infection of the blood stream, or of the brain--meningitis--both.

Merrow: His skin looks so different from--from my own baby's--it's almost papery appearing.

Goldsmith: Over a period of time, uh, babies begin to lose the subcutaneous tissue, or the tissue fat under the skin. One of the biggest advances we're making in this decade, or the last decade, has been nutrition of these very small babies. Dr. Drillian in England showed us many years ago that if we didn't give the baby nutrition--we used to fast premature babies--large numbers of them would end up, uh, with mental retardation. And initially we started just giving them sugar, because we knew the brain cells needed sugar--IV--IV sugar--intravenous sugar. Now we can give sugar intravenously, protein intravenously, minerals intravenously, trace elements--zinc, copper--intravenously, and most recently fat, we can give fat intravenously. So that we can get up, on a baby, to the calories required to grow. Even though this baby has never taken anything through his gastrointestinal tract, we can give enough calories by giving a combination of sugar, protein and fat, for that baby to actually grow in this unit.

Merrow: This little baby has a respirator, and he also has something through the umbilicus, something up in the chest, and then several tubes, it looks, in both wrists.

Goldsmith: Mm hmm.

Merrow: He's a--he's a bundle of tubes and needles.

Goldsmith: All right, let me try to explain this. This baby has a catheter giving him, uh, probably some intravenous sugar, but probably most likely just for monitoring arterial blood gases through his umbilicus--through his belly button. He then has an attachment on the middle of his chest, which is his probe for his heat. That goes to the radiant warmer and is the thermostat to regulate his temperature. He then has on monitoring leads--there are three of those--on his chest, upper and lower, that goes to the monitor, and he's monitored for his heart rate. He then has a tube into his mouth, which is the endotracheal tube for the respirator--that's to breathe for him. He has a tube down his--also down his mouth that's probably into his stomach, or maybe past the stomach--again, I'm not in the unit this month so I'm not familiar with the babies--but possibly for feeding. He has an intravenous--IV--in his left arm which is giving him right now, uh, the protein material, and, uh, he has also an intravenous in his right arm which is probably, uh, giving him some other kinds of medicine. All these things have to be monitored very carefully so that we don't give the baby too much fluids. Therefore, the need for electronically monitored fluid drip-dramers. It used to be, in medicine, we take and hang a bottle or a bag of IV fluid, hang it up, and the nurse would adjust it according to her watch. I remember

in the old days, if we wanted to take something that a nurse did, she came in and she looked at her watch, and she watched the drips going down, and she counted the drips. This is all done by electric eye now. And we can make very, very small drops. Again, this is--again, part of the technology of--of an intensive care unit.

MERROW ASKS ABOUT THE DANGER OF THE TECHNOLOGY

Merrow: The technology. What damage could you be doing with this technology to this child? What diseases could you be causing? What--what harm?

Goldsmith: Well, we know that we have iatrogenic diseases--iatrogenic diseases means diseases caused by physicians--because of the technology. The question is, is the outcome worth the technology? If this baby survives, does that mean--is that important? Come with me.

This is a board where nurses collect pictures sent back to them by parents of our graduates. And generally the sickest children are the ones that stay the longest, so they develop, uh, feelings, and they start to send pictures back. And this is only one month's supply of pictures, because they get taken down and redone--month by month we get hundreds of pictures from parents. And you can see--I mean, if that were your child at four or five years old, that little girl, she's a normal--I happen to know that child personally. that's a child that was two and a half pounds at birth and looked as bad as the babies that you're seeing in here. Is it worth it? Is it worth any amount of money? How can you quantitate that? I don't know. I really don't.

Merrow: But speak specifically about the kinds of diseases that you might be causing with this technology--creating an infection, the bruising of the lungs because of the respirator, even blindness if the oxygen supply is too great--that sort of thing.

Goldsmith: We know that a certain number of the children may, uh, have bruising of the lungs, or bronchal pulmonary displeasia, uh--there's hope in that, in that that disease resolves over time. For example, a baby is born with about 30 million air cells--alveoli--in his body when he's born. When he's six or eight years old, he has 300 million. So only 10 percent. So if we can get him over the hump, and get him growing, those 10 percent that we've damaged with our respirator probably won't be any worse than living in the city of New Orleans. (laughter) Or, obviously, smoking. So, whereas many of these children will have recurrent respiratory infections--some of them go home on oxygen, with oxygen cannula under their nose--if we can get them to gain weight and grow, the prognosis is excellent, because these babies get better. Um, the pulmonologists--those are the experts in lung disease, pediatric lung specialists--are seeing many more of these patients, and they are very similar, in many respects, to children with cystic fibrosis who have lung disease. The difference is that these children get better, and the ones with cystic fibrosis get continually worse, and eventually die. So we're very, very positive about this kind of--of disease,

although we know that it's caused by our ventilator.

Now, let me show you one of our newest inventions of technology. This is a trans-cutaneous oxygen electrode, and what this does is, is that by putting a sensor on the skin, we can read out the oxygen content in the blood. Now we know that too high oxygen content in the blood may cause blindness, and too low oxygen content in the blood may cause mental retardation. And so we want to monitor the oxygen in the blood very, very closely, and keep it in very defined limits. Now, if we take a sample of blood, it only tells us what the oxygen content in the blood is in that one moment in time. This trans-cutaneous monitor with alarms at high and low setting can now let us fix the oxygen where we want, so that the baby is monitored continuously, and his oxygen is monitored continuously, and we can therefore better control it. Hopefully our outcomes will be better. Unfortunately, this type of device costs about $12,000.

Merrow: And it can only be used on one child at a time?

Goldsmith: One baby at a time! So if we have a neonatal intensive care unit here that has 16 intensive care beds, we don't have 16 of these--I'd like to have 16!

Merrow: Was it on this little baby here?

Goldsmith: Yes, it was. And that baby is now coming out of oxygen, or is out of oxygen and is starting to move around and looks quite good.

Merrow: He does? He looks quite good?

Goldsmith: He does! He looks great!

Merrow: That's the tiniest baby I've ever seen!

Goldsmith: Although he's looks small--he's under two pounds--you can see by the flexion in his arms and his knees, and he's moving around, and he's quite healthy and quite happy, and, uh, his skin color looks good, his--he looks like he's got some subcutaneous tissue other than the baby that you just saw where the baby was sick--to a practiced eye--in fact, he just yawned at us he was so bored! Despite the fact that that baby is so small, that is a quality premature baby who's probably, very honestly, going to be quite--quite a good survivor.

Merrow: But he's still on the respirator--in the incubator.

Goldsmith: He's still in the incubator, and that is a type of respirator. But that's very interesting that you pick that up. Because he's on a--a type of waterbed with an air flotation mattress under it. So he's on a waterbed, because he forgets to breathe. This is just a--a very basic ventilator, not the sophisticated type we have over here. And all it's doing is pumping up the air mattress, and you can hear the "whoosh," uh, 15 to 20 times a minute, and rolling the water under him so he continues to get stimulation--he seems to like it; as you can see he's kicking around and moving around, and--and doing nice things. Now, the question comes up, can this baby sleep

under these conditions? What happens to his psyche? What happens to anybody in an intensive care unit? A study was done that showed that the average child or neonate in the resperitory--in a neonatal intensive care unit--gets "attacked," assaulted by nurses, physicians, therapists, lab technicians 140 to 150 times a day! To the point of crying! What does that do to your psyche? We don't know. We honestly don't know. Um, but we think it's important for future investigation, and we're looking into those things now. We know we need to--to be in contact with these babies. We don't know whether we need to be in contact that much, and probably we should give these babies more quiet time.

Reinhardt: Dr. Jay Goldsmith, head of pediatrics and neonatology at Ochsner Clinic in New Orleans. The existance of this technology, and the relentless pressure to use it and to improve it, mean that today, 20-week-old fetuses are being aborted in one wing of a hospital while 24-week-old fetuses, in another wing of the same hospital, are being resuscitated and saved. Where do we draw the line? Pediatrician Frederick Greene.

A PEDIATRICIAN DISCUSSES THE ETHICAL PROBLEMS RAISED

Greene: This is a very personal struggle, I think, the: all of us in medicine who are involved in this have to deal with. The--and I'm not speaking of the "anti-abortion, right to life issues," but I think that the--the whole issue of--of the--the sparing of the human life, the saving of the human life, and at what price--I remember as a medical student, I had a professor of pediatrics who used to--he questioned our attempts to save the lives of half-pounders and--and so on. And he used to say, "You--you're saving them, but what are you saving?" Well, uh, recent work has shown that, uh, sometimes we're saving pretty good people. Sometimes we're saving, uh, headaches for families, that's--that's true. There are times, of course, when, uh, questions are raised. And we need to consult with, uh, family and the clergy and the bioethicists as to a child who is literally living through the machines.

Reinhardt: Can you give me a specific case--someone--some that you've maybe seen recently.

Greene: Well, a number of years ago, I remember a four-month-old infant that I knew that had a streptococcic sepsis, and that means that there was a--a blood infection with the streptococcus, and the child had had the brain seeded, so that the child had a meningitis--had had a pneumonia, and had the kidney involvement, so we had lines going in to support respiration, we had intracranial lines, we had lines into the urinary tract, we had lines going in every place, monitors beeping all over, and--and, uh, there--there came a time when the--the, uh, the EEG sort of flattened out, but then other lines were beeping. And you--you know, the point is that you, uh--where do you stop? And this is not a decision for the physician alone to make at all. There have been many better minds than mine that have been struggling with, uh, what is life and, uh, when do we, uh, call a halt to, uh, heroic efforts to

sustain it. So anyone that tells you that we have the answer to this, uh, may not really understand the question.

Reinhardt: Frederick Greene, pediatrician and associate director of Children's Hospital in Washington, D. C.

GOLDSMITH COMMENTS ON THE ETHICAL QUESTIONS

Goldsmith: The ethical issue is based on ethics, and religion--I hope not on economics, but possibly sometimes on economics--and that is, do we resuscitate? Now if a baby is born without a brain, called an anaencephalic . . .

Reinhardt: Pediatrician Jay Goldsmith.

Goldsmith: . . . nobody touches those babies. They don't live very long, and we know they all die, that's fine.

Merrow: You could save those, though--babies?

Goldsmith: We could put that baby on a ventilator and keep it alive for several days to weeks, but that's absolutely out of the question. But there are all gradations, and--I guess it determines--one of it is meaningful life--what is meaningful life, can this person have a meaningful life? One way people get around it is that, at least there are some religious sources--the term extraordinary care. There is judgment--you can use judgment on resuscitational--or on caring for a patient--if you have to use extraordinary care, and if there is hope of the patient leading a meaningful life. Those two seem to be the key. Now if, for example, a baby falls above the weight category as being greater than 11 ounces and greater than 20 weeks of pregnancy--gestation--which is our definition of a live birth, but is not considered viable, that is, is less than 24 weeks of gestation--26 weeks of gestation--and we can tell this by looking at the baby--we can't tell it terribly accurately, but we can get a judgment--then we may give the baby support--that is, IV sugar and warmth and oxygen, and see what happens to the baby.

Merrow: In other words, you don't do extraordinary things.

Goldsmith: We don't do extraordinary things, and on one occasion at least, in my memory in the last five years, we did that and the baby survived. We felt the baby was pre-viable, but gave the routine things, and the baby survived and did well, and is normal, at a two-and-a-half-year follow-up, I might add.

MOTHER OF A NEWBORN IN A NEONATAL INTENSIVE CARE UNIT

Mother: When she was born they told me, "Forget it," that she was too small, and--she's a fighter, she's here.

Reinhardt: How much did she weigh when she was born?

Mother: One pound, twelve ounces--but here they do it in grams--830 grams.

Reinhardt: Was she premature?

Mother: Yeah--six months!

Reinhardt: Oh, she was born when you were only six months pregnant.

Mother: Mm hmm. Yes.

Reinhardt: She is beautiful. She really is.

Mother: Yes, definitely! I can say that. You don't have to! (laughter) Yeah, she is pretty! Her haircut--I said in her baby book it's going to have who gave her her first haircut. But I don't think it was really a haircut--it was a shave!

Reinhardt: Is that for--for the things that they have to hook her up with?

Mother: Um, sometimes they put an IV in her head, or give her blood, and--which is good for her, because she's active. She likes to move her hands and her legs and--so the IV in her head--at first I thought, "Ohh, her head!" But it's really--she likes it better there.

Reinhardt: But she does--she does move her legs and arms a lot, doesn't she?

Mother: They tie her down--(laughter)--because she squirms so much. If she wasn't tied down, it's a possibility she could flip right off. She is that active.

Reinhardt: Isn't that a good sign, though?

Mother: Oh yeah. The--the more active they are, the better--better chances they have.

Reinhardt: Have you held her only once, then?

Mother: Yes. That's enough to--it really makes you nervous, 'cause there's this tube--the Z-T tube goes down into her throat--.

Reinhardt: And that's what breathes.

Mother: Right. And if that moves, she turns blue on us. So I'd rather not hold her, 'cause it's--you know, it's not good for her. And I--you know, it's hard. So you just let her lie. She moves around enough. She gets enough exercise. And you get to do things, the nurses let you--you can hold her hands, you can clean her bottom--they let you do that a lot! And, uh, there's lots of little things you can do that makes you feel pretty good, not total mother, but makes you feel good.

Reinhardt: Do you ever think about what if she'd been born 20 years ago?

Mother: No. I'm just glad she wasn't. It's--I often thought--I've told the nurses this--you--everybody knows neonatal intensive care, but you really don't know until you're here.

Merrow: Next, health care for poor children.

Reinhardt: Copies of this four-part series on children's health care are available. The cassette recordings cost $14.00; the printed transcript costs $6.00. Here's how to order. Call this toll-free number: 800 253-0808.

Merrow: Let me give you that information again. Cassettes of the four programs, $14.00; the complete printed transcript, $6.00; and the toll-free number is 800 253-0808. If you live in Michigan, call 616 471-3402.

Reinhardt: If you'd like to write directly to us, our address is National Public Radio--Education, Washington, D. C. 20036.

Reinhardt: When do you think you'll get her home?

Mother: July. July.

Reinhardt: Is that when she was due?

Mother: Yes. But if she's got to stay here August or September, okay. Whenever she's ready, we're ready.

Merrow: OPTIONS IN EDUCATION is a co-production of National Public Radio and the Institute for Educational Leadership of the George Washington University. Support for the series is provided by the National Institute of Education and the Corporation for Public Broadcasting.

Reinhardt: OPTIONS IN EDUCATION is produced by John Merrow. Rebecca Goldfield serves as associate producer; our engineers are Dennis Herndon and Greg Hedgepath. I'm Barbara Reinhardt.

Merrow: I'm John Merrow, and this is NPR--National Public Radio.

Reinhardt: Twenty to 25 percent of the children in this country live in poverty--that's between 13 and 15 million children, white, black and brown. Those children are four times more likely than middle-class children to be in poor to fair health. What kind of health care do poor children get?

MERROW TALKS WITH A MOTHER WHO BROUGHT HER SICK CHILD TO A COMMUNITY HEALTH CENTER

Merrow: How old is she?

Mother: The baby?

Merrow: Yeah.

Mother: A year and five months.

Merrow: Seventeen months.

Mother: Yeah.

Merrow: How old are you?

Mother: Seventeen.

Merrow: Seventeen years. Seventeen years, seventeen months.

Mother: Yeah.

Merrow: What's wrong with her?

Mother: She had a cold, an ear infected, a black eye.

Merrow: An infection in her ear?

Mother: Yeah.

Merrow: She must have a fever.

Mother: Uh huh.

Merrow: What's her temperature?

Mother: A hundred and something.

Merrow: What's normal?

Mother: I don't know yet.

Merrow: Did you take her temperature at home?

Mother: No, I didn't take her temperature at home, because I had--I had no--you know, the thing which you put in her mouth--I ain't had that.

Merrow: What will happen here? What will they do for her, here at the clinic?

Mother: They'll probably give her some cold syrup, some medicine for her cold and stuff. And . . . to them for to get some Tylenol to bring her fever down.

Merrow: How long has she had the fever, do you know?

Mother: Since last week.

Reinhardt: That young mother doesn't know some of the things we'd probably agree parents need to know. She has taken her baby to a community health center, and although her baby's problem--a raging ear infection--will be taken care of, no one at that overcrowded and understaffed health center is going to teach her what to do next time.

Doctor 1: Your baby has a cold?

Mother: Yes.

Doctor 1: Aha. She has fever. Hi! You look quite good! Huh? How you feel? Okay? She has a temperature, a hundred and two. You giving her any medicine?

Mother: No.

Doctor 1: No?

Mother: Huh uh.

Doctor 1: The nurse just gave her the medicine?

Mother: She gave her some a long time ago.

Doctor 1: Oh, all right. She had the ear infection then, okay, as you suspect. All right, so, has she had ear infection before?

Mother: Yes, she had an ear infection before.

Doctor 1: Often?

Mother: Yeah.

Doctor 1: Okay, why don't we do this. I'm going to give you a prescription for the medicine for the ear infection. All right, you know about this, it's for the ear infection. You have to give it to her three times a day, every day, for ten days.

Mother: All right.

Doctor 1: All right?

Mother: All right.

Doctor 1: And then, uh, we'll have to check her ears again two weeks from now.

(baby's crying makes it hard to hear)

Mother: Huh?

Doctor 1: (laughter) We'll have to check her ears again two weeks from now.

Mother: All right.

Doctor 1: All right. So, you have any cold medicine for her?

Mother: No, I don't have nothing like that. You going to give her some vitamins too?

Doctor 1: Why does she need vitamins?

Mother: 'Cause she had lost some weight--she was weighing more pounds than she weighing now.

Doctor 1: And what she was weigh before?

Mother: She was weighed 29 pounds. Now they say she weigh 20 pounds.

Doctor 1: I mean, won't help her gain weight--have nothing to do with vitamin. Okay, right now the most important thing is get rid of this ear infection. Okay? So we'll re-check her again two weeks from now and we'll talk about it. All right? So we'll give you a prescription of the cold medicine and the ear infection, and we'll check you again in two weeks. Any other questions?

Mother: Not right now. Are you going to give me an appointment?

Doctor 1: Yes, we'll give you an appointment in two weeks.

Mother: To bring her back?

Doctor 1: To bring her back--two weeks. All right? Okay.

Reinhardt: About 25 percent of our children--most of them white, by the way--get their health care the way that baby does, at some sort of public clinic or hospital.

Merrow: We're talking about 15 million poor children, 9 million of whom have no regular family doctor. Some poor children never see a physician. I'm John Merrow.

Reinhardt: I'm Barbara Reinhardt, for NPR's OPTIONS IN EDUCATION. In one program alone, Medicaid, the federal government spends $2.7 billion on health care for poor children. Twenty-five other federal programs provide some health services for children. Every state has its own programs as well.

Merrow: The health needs of the poor are not the same as those of non-poor. Poverty brings more problems, and different ones too. Dr. Frederick Greene, of Children's Hospital in Washington, D. C.

PEDIATRICIAN DISCUSSES CHILDREN'S HEALTH NEEDS

Greene: Kids are healthier today than they were. Uh, more kids do survive. Infant mortality has, uh, dropped to a major degree. I think in--on the whole, uh, nutrition of children is better. But the same point, uh, the have-nots--the discrepancy between the, uh, health status of the haves and the have-nots--the--the lower socio-economic, uh, classes and the more affluent, has remained very marked, and best represented by the health

status between white and non-white. There has been an improvement all along, but the discrepancy between the two remains.

Reinhardt: Are there such things as diseases of the poor, or health problems of the poor, problems that the poor have much more than the non-poor do?

Greene: Oh, I--I think so. I think the, uh, things that come immediately to mind are health problems, uh, that come about as a result of inadequate attention to, uh, to acute problems. And I'm thinking--for example, neglected middle ear infections. Whereas the suburban and the more affluent mother can often get the kid in with that otitis--with the middle ear infection--and have care and follow-up, sometimes a little kid who's a latch-key kid--do you know what a latch-key kid is?

Reinhardt: Yeah, why don't you tell though.

Greene: Well, a latch-key kid is a--is a child whose parent, or maybe single parent and so on, works and there's no one to provide care. So they have the key around their neck and they can let themselves in and out of the house. So that child may not have the--uh, not the luxury, but the right of having his middle ear checked up constantly. And so you have chronic infections. I guess this falls in the area of secondary prevention. Primary prevention is the prevention of disease; secondary prevention is the prevention of the consequences of disease. And I think that's a big area, when you talk about the difference between the more affluent and the poor.

Reinhardt: Can you give me another example?

Greene: Common problems--eye problems as well. You know, uh, the, uh, uncorrected, correctable physical deficits, if we can look at it in that light, is--is a very major problem, and probably exists much more in the, uh, the--the poor, the less affluent, the lower social classes, than in others. Because even our system sets up, uh, disincentives for the use of the health system for preventive care. And that's why many of us feel very strongly that we must provide incentives for people to bring children in for a well-child check-up, instead of their having to wait to take off work, and they'll only take off if the child is sick. The--I feel it is a responsibility of the health care system, not only to provide care to people, but to make people aware of what to expect when they go to facilities. I believe that the health care system has a responsibility to teach people how to use the system, what to expect of the system, where to get care--the how, when, where, and the how to use systems. But, uh, so often, as I pointed out before, we're often short-circuited in that, because our system--we'll say, well, we're only--our clinics are only open 9 to 5, from Mondays through Fridays. And the parent works at that hours, and so the only time they're off is after dinner in the evening or on the weekends, and then the clinics are closed. And if they don't have a private physician, they may come into an emergency room and get bawled out by someone that they're using the emergency room inappropriately, which is what happens quite often.

Remember that in our country, 75 percent of our children are cared for in the private sector of care. But 25 percent of the children are cared for in the public sector, in the public clinics, where the care is less personal, where it's less continuous, and where the care tends to be, uh, far more vulnerable to political influences.

Reinhardt: Dr. Frederick Greene, a pediatrician at Children's Hospital in Washington, D. C. Today the budget is the most vulnerable part of children's health care. The Reagan administration wants to cut federal funds to health care by 25 percent.

Merrow: According to pediatrician Jay Goldsmith, many--maybe most--of poor children's health problems begin in the womb, before the children are born.

GOLDSMITH DESCRIBES PRENATAL INFLUENCES ON THE HEALTH OF CHILDREN

Goldsmith: Probably the most important of the, and I won't say diseases, but conditions that affect the non-poor is nutritional differences. Uh, the quality of the diet that a mother receives is going to affect her baby. Several years ago a doctor took two groups of rats. In one group of pregnant rats, he tied off the artery going to the uterus, and thus affected the blood supply to the baby--the baby rats. In another group of rats, he poorly fed the mother--very low protein in the diet, just as if you were on a junk food diet in the United States. The rat babies were then delivered, and allowed to--and fed normally, same diets, et cetera. Both groups of rat babies were undergrown for their gestational age--that is, they were smaller than would be expected--one group because they were protein-deprived from nutrition, the other group because a mother with one artery tied off to the uterus had less blood flow and, uh, had less nutrition--a less blood-oxygen exchange. What they found was that in these two groups of rats, the group that, uh, was undernourished, uh, was a "dumber" group of rats--that running through mazes, et cetera, they couldn't find their way, et cetera. And then when they sacrificed the rats and weighed their brains, and measured the protein content through DNA, that there was less DNA and less brain content. And that the rats that were--had the problem with mothers having a uterine artery cut off, after fed, recovered and had, uh, better times running through and were smarter, quicker, and when they examined these rats, that the brain content of protein and DNA was greater than the other group.

The implication for this is--is tremendous, in that we, as pediatricians, especially neonatalogists--those specializing in prematures--we can feed and nourish and put babies on a respirator after birth and get them through. But the die, many times, has been cast prior to that baby ever coming out of the womb, ever coming out of the uterus, in that that baby's, uh, makeup of how much, uh, brain content, protein content, may have been totally determined in the womb, and may be dependent upon what the mother does--whether the mother has good nutrition, uh, and whether she smokes, whether she's an alcohol user. And we find that low socio-economic people have babies that are

different for this reason. Um, and that even applying the same medical care, after the damage has been done, the outcome is going to be different. And thus there is a vicious cycle that a poor mother will give birth to probably a poorly-born baby.

Merrow: We used to say, "You are what you eat." But you're saying, no, it's not that at all. "You are what your mother ate."

Goldsmith: In many cases, yes.

Reinhardt: Dr. Jay Goldsmith.

Merrow: The United States does have a system for delivering health care to poor children. Some services are provided in school, often including eye and dental check-ups. And schools generally require proof of immunization before they'll enroll a child. Community health centers, like the one that 17-year-old took her baby to, provide care for many poor children.

Reinhardt: Lower Ninth Ward Community Health Center gets federal, state, and local money. In addition, those patients who can afford to, pay. Fees are on a sliding scale. Last year the center handled 30,000 cases--everything from obstetrical and gynecoligical care to emergency room treatment of burns and stabbings.

Merrow: The lower ninth ward itself, where the health center is located, is a neighborhood of about 40,000 people--75 percent of the adults are working poor--not on welfare, but earning not much more than welfare would pay. Even though most of the adults are at work during the day, the clinic is open only during regular working hours--8 to 5:30, five days a week.

Reinhardt: That's nine and a half hours a day. Only two years ago, the clinic was open 13 hours a day. Last year, because of budget reductions, the hours were shortened to 11 1/2 a day. This year's budget cuts reduced the hours again. Clinic director Ella Bogan wishes the trend were moving in the opposite direction--more hours, more clinics.

CLINIC DIRECTOR DISCUSSES THE EFFECT OF BUDGET CUTS

Bogan: I really don't believe there is enough, uh, medical facilities in communities. All right, let me say that. I think that for poor people--they need to have clinics in their own communities. Because transportation, number one, mainly is a problem. You know, for instance, we have mothers who are coming here with four or five kids at a time. And many of them are in the age range where as, if they were boarding the bus, they would have to, uh, they would have to pay, you know, to ride. So, I believe that if we had more community health centers, where as patients can come into their communities and get service, uh, not only--not only will it help them economically as far as for riding the bus, or going outside of their community, you know, by car, I think it would also give them a more personalized service. Because, using our clinic as an example, those persons who live here--who work here--are

persons who have either lived in this particular area or is living in this particular area. Many of the patients have been coming here particularly, since day one, and we kind of--we really just know them, so it's like a personalized thing. It's not like going into a charity hospital system where, you know, you have, uh, hundreds of people needing to be seen at--on that same day, or the day after. But it's--and it becomes very impersonal, and it's just really like--like a number again. But here, in an--in a smaller community setting, you have the personalized service of which everybody can come in and be treated with dignity and respect.

Merrow: You're trying to have a system that's really very much like the middle-class system--you have your family doctor, you call up, make an appointment, go in three days later, or two days later, or whatever.

Bogan: Yeah, yeah--well, if that's what you would call it, maybe so. We do push for the appointments, because, uh, not only is it a better continuity of care, uh, but, uh, we're able to get to the patients faster, you know, because there's--for instance, the charts are pre-pulled, uh, all of the requirements that's necessary for them to register, perhaps, are done before their appointment date, all right. Whereas if they just walk in, all of these things have to be done then on the spot. But they still can walk in if they need to. And that's another, I guess, good phase of the community center.

Merrow: What's going on with the people in the community who aren't coming here? You're in a part of New Orleans that has some boundaries--it's hard to get, say, to Charity Hospital--you said over an hour away by bus. What kind of health care are those people getting?

Bogan: Other than the other family practice that's in this particular area, I guess, uh, zero to none, if there's any such scale! (laughter) Really, I just think there's some of them out there that--that are just not getting any health care at all. I really do. For instance, a lady was in this morning, her baby had been sick for about a week, and running a fever and, you know, a temperature and everything. And, uh, and I asked her, you know, what has she been doing. She said, "Well, I did everything, and the last thing I did was an alcohol bath, and it still wasn't doing any good. So I decided to bring it in--to bring him in." And it just dawned on me, you know, well how many other people are out there doing the same thing, you know, thinking that they can cure it themselves, and--and just not doing anything. And of course if the fever breaks, uh, they probably feel the child is cured, which is not--does not necessarily mean, uh, that it's true. But it subsides enough where the parent might feel, "Well, I don't have to come in." And I don't think these are people--don't get me wrong--I don't think these are people who are willfully neglecting their children. I think these are people who are just trying, with everything they have in them, you know, to do the best they can at home. And, uh, I guess they figure it worked for them, so it can work for the child.

Merrow: Maybe they're afraid to come into a clinic. Maybe they don't have the $3.50 or $4.50--which is the lowest rung on your fee schedule.

Bogan: Yeah, yeah, and that's highly possible. You know, you--for some of us, we might say $3.50 is nothing for your child's care, but if you have a mother out there with five or six kids, and, uh, and, uh, $3.50 might be like $30.50 to her, you know.

Merrow: And you might have to take a bus to get here, which would cost you some money, especially if you have to bring the other kids--.

Bogan: Right, and we have--we do have quite a number of patients who, when they do break down and come, they will bring three or four kids at the same time. And it--it makes sense, you know, because, uh, it costs--it costs a lot of--like for instance, in this particular area, the bus service is very poor--we only have two bus lines, and there--there are so many blocks in between wherever the bus stops--for the two bus lines that we have--that for--for many of them, either they have to get a ride, um, if they don't have a car, or they have to walk. And that in itself is, uh, I'm sure kind of traumatic with three or four kids trying to get to the clinic.

Merrow: So those are incentives not to come here. And those are incentives to try home remedies.

Bogan: I would say. I could see it easily. You know, without being negligent in any way. They're just trying to do whatever possible--even for the $3.50, that might mean two or three loaves of bread, you know, rather than coming over here to--to give it for medical care.

Merrow: I spent last night and quite a few hours yesterday in the pediatric emergency room at Charity Hospital. And I think half the women I talked to who were there with their children who had fevers, they had not taken the kids' temperature. They just felt the kid was listless, the kid felt hot, but they didn't take their temperature at home. Now is that common?

Bogan: Mm hmm.

Merrow: Not taking the temperature at home, not having a thermometer handy, or not knowing enough to do that?

Bogan: Mm hmm, yeah. It is very common, that many of them will come in and, uh, either they don't have one, or I dare say that some of them doesn't even know how, you know. Maybe it might be even better off for some of them who doesn't, if they feel the child is hot and listless, it's better that they bring them to some medical facility. Because if they don't know how to read it, that's just as dangerous as not taking it, you know, because they could get a reading and not know really what it is. But I--I think for many of them who will come in, they will--the kinds of things they will say is that, "Well, how do you know he has a fever?" "Well, he's been hot, you know, and he's--he's been sweating, um, you know, um, he's just been laying there," you know, or whatever, and that they know

there's something wrong, but not to what extent they don't.

Reinhardt: Ella Bogan, director of the Lower Ninth Ward Community Health Center, one of three in New Orleans, one of about 2,500 in the country. The 1,000 federally-funded centers may have their budgets cut. According to the National Association of Community Health Centers, the cut the Reagan administration is proposing would close one third of the centers, and deny services to nearly one and a half million patients.

Merrow: Judy Weitz, of the Children's Defense Fund, describes the proposed cuts.

WEITZ DESCRIBES THE EFFECTS OF THE FEDERAL BUDGET CUTS

Weitz: There are essentially two different kinds of cuts the Reagan administration is proposing. The major one is the change in the Medicaid program. About 13 million children are now eligible for Medicaid, and that's about 45 percent of the eligible population. And what he is proposing to do is to end the entitlement nature, the open-ended funding nature of that program, and to place a cap on Medicaid. That cap would be roughly a 5 percent increase over fiscal '81 spending for fiscal '82--that's a billion dollar cut over projected figures for '82 in Medicaid, in the federal portion of Medicaid.

Merrow: A cap means once the money is spent, that's it.

Weitz: That's it, as opposed to the way the current program operates. As long as there are eligible people, and the state is serving those people, the state, if they are paying their portion, can pull down federal dollars, uh, for the cost of that care. That would end--that would no longer be true. They could only pull down federal dollars up to the fixed amount that they are allocated, uh, by the federal government, under the Reagan proposal.

Merrow: So even if there were more poor children, in this case, needing the care, they wouldn't get it because the money is gone?

Weitz: Precisely. Precisely, even if there are changes within the state--for instance a rise in unemployment so there are more families who are eligible, whatever. There is no accommodation for any of those changes.

Merrow: That's one cut. Go on.

Weitz: The second cut is that the Reagan administration would abolish--and I emphasize abolish, because there's a lot of misunderstanding about this--25 what are called categorical health programs that affect a lot of people, but a lot of mothers and children, which is our particular concern. They would be abolished--th funds, the federal funds for those programs would then be allocated to two separate block grants that would go to states to fulfill some of the same purposes, but with none of the protections--accountabilities, state funding, state matching funding--that currently goes on through the existing programs.

Merrow: Well, the way you say it makes it clear that you object, but it would get rid of the red tape--that governmental red tape we hear about--25 programs collapsed into two does make some kind of logical sense, doesn't it?

Weitz: I think there is a logic in--in this sense. There are programs which could be consolidated. Consolidating programs is different than block-granting them--abolishing them and block-granting them. By consolidating, you take what works and you coordinate them one with the other, and get rid of some of the administrative duplication. That is not what's going on. The other thing I'd point out is that the best estimates we've been able to get a hold of, both from state officials and the Congressional Budget Office, show that, um, administrative costs of these programs run around 7 to 10 percent of total costs of the program. The Reagan administration is cutting those programs by 25 percent, because of supposed administrative duplication. Well, you can be sure there has got to be some cut in services as well when you get that discrepancy between what's actually being spent in administrating the programs and the 25 percent cut. Understand too that on top of that there's inflation, and experts figure that the real cut is closer to 30 to 40 percent.

Merrow: You said that the block grants, if they go through, will do away with requirements for matching funds from the states. Does that bother you?

Weitz: Yes, it certainly does. And one of the programs that would be abolished is the Title Five Maternal and Child Health and Crippled Children's Program. That is a program that has been around since 1935--it's not a Great Society program! It's a--a federal priority to serve mothers and children that was started in 1935. That program would be abolished. Almost one third of the funding that states can use, um, to fund core services for children--that is, health check-ups, immunizations, eye examinations, dental care, prenatal care for pregnant women--one third of that money would disappear. Because, not only do you have a decrease--a 25 percent decrease in the federal funds that will flow into the state for any such purpose, um, you also have no requirement that the state put any money into that pot for that purpose.

Merrow: Judy Weitz, of the Children's Defense Fund in Washington, D. C. In the last part of this series, how poor families use hospital emergency rooms as their family doctor.

Nurse: Is he allergic to any medicine that you know of?

Mother: Not that I know of.

Nurse: Last name?

Mother: Barnes.

Nurse: First name?

Mother: Irving.

Nurse: How old is Irving

Mother: Six weeks.

Nurse: Birth date?

Mother: Uh, March the 14th, 1981.

Nurse: He's been crying like that all night?

Mother: Mm hmm.

Nurse: Okay, bring him into the room behind me, get his temperature and weight taken.

Reinhardt: If you'd like a copy of this four-part series, just call this toll-free number: 800 253-0808, and ask for the OPTIONS IN EDUCATION series on Children's Health Care. Cassettes and transcripts are available. You can get the details over the phone. The number again is 800 253-0808. If you live in Michigan, call 616 471-3402.

Merrow: If you want to write to us directly, our address is National Public Radio--Education, Washington, D. C. 20036.

Reinhardt: OPTIONS IN EDUCATION is a co-production of National Public Radio and the Institute for Educational Leadership of the George Washington University. Support for the series is provided by the National Institute of Education and the Corporation for Public Broadcasting. John Merrow produces this series; Rebecca Goldfield is our associate producer. Our assistant producer is Alex Van Aus; and our engineers are Dennis Herndon and Greg Hedgepath. I'm Barbara Reinhardt.

Merrow: I'm John Merrow, and this is NPR--National Public Radio.

PATIENT IN PEDIATRIC EMERGENCY ROOM

Merrow: Tell me what's wrong with your little girl?

Mother: She's just run a high temperature--it started just this morning.

Merrow: How high?

Mother: A hundred and four.

Merrow: Just started this morning?

Mother: Mm hmm, yes.

Merrow: You come here from a long way away. How far?

Mother: Twenty-five miles.

Merrow: Why do you come here?

Mother: Because I got a hospital card to come here for her.

Merrow: Why do you have a hospital card?

Mother: Because all the other hospital's pay hospital, and I can't really afford it, so we come here.

Merrow: This one doesn't worry about whether you can pay or not; they'll take care of your child?

Mother: Yeah. I took my little girl to Chaumette, she went roller skating and she fell and hit her head, and she had a hematoma. And I took her to Chaumette, and they wouldn't even look at her unless I paid $2,500 cash.

Merrow: What did you do?

Mother: I brought her to Charity and they admitted her and did surgery on her three days later.

Merrow: She's okay--here she comes.

Mother: Yeah. She's doin' fine. And if it wasn't for Charity, she would have been dead.

Reinhardt: The pediatric emergency room of a public hospital serves as her family's private doctor. She brings her four children here for emergencies, and routine medical care as well.

Merrow: Many poor people get medical attention in public hospital emergency rooms, if they get it at all. I'm John Merrow.

Reinhardt: I'm Barbara Reinhardt for NPR's OPTIONS IN EDUCATION. In this final part of our series on children's health care, we take a look at public hospitals, whom they serve, and how.

Merrow: Do you like this hospital?

Mother 2: It's okay--no better than anybody else's hospital. They got pretty good doctors here.

Merrow: Well, suppose you could go somewhere else. Where would you prefer to go?

Mother 2: I really don't know, you know. If I had my own private physician, well, I'd probably bring him over there.

Merrow: Why don't you have your own private physician?

Mother 2: Because I don't have it--I can't afford it right now.

Merrow: What's the difference--what's the cost difference, here and a private physician?

Mother 2: Well, when you have--in a private physician, you have to pay when you first get your--when you come in there, you have to pay.

Merrow: Not here?

Mother 2: No, not here. They'll bill you afterwards.

Merrow: Oh, so you have like a two month wait before you have to pay. Is that important to you, that two month lag?

Mother 2: Yeah, yeah, mm hmm. Very. 'Cause half the time you don't have the money when your children are sick.

Merrow: But you'll pay.

Mother 2: Yeah.

Merrow: It's not free for you.

Mother 2: No. It's not free for me.

Merrow: If you were on Medicaid, if you weren't working, if your income were below a certain level, it would be free, right?

Mother 2: Right. But I'm not.

Merrow: Since you're working, that means you pay.

Mother 2: That's correct. That's no more than fair.

Merrow: Even with a--almost a five-hour wait--.

Mother 2: Well, it's worth it if your child is sick, or if you're sick, it's worth it, you know. Don't make any difference. You're going to have to wait either way you go. Even at a pay hospital, you still have to wait.

Reinhardt: She's a patient at Charity Hospital in New Orleans, a public hospital started in 1736, and once run by the Sisters of Charity--that's how it got it's name. Charity Hospital is the biggest medical facility in Louisiana. It takes care of one million patients a year. And at one time, it was where everybody went. Today its patients are virtually all poor. Charity's pediatric

emergency room is open 24 hours a day. Patients first check in with the triage, or screening nurse, who determines whether the situation is a genuine emergency requiring immediate attention, or something more routine, like an ear infection or fever.

TRIAGE NURSE SCREENS INFANT, AND EXPLAINS WHY PATIENTS USE THE EMERGENCY ROOM ROUTINELY

Nurse: Is he allergic to any medicine that you know of?

Mother: Not that I know of.

Nurse: Last name?

Mother: Barnes.

Nurse: Birth date?

Mother: Uh, March the 14th, 1981.

Nurse: He's been crying like that all night?

Mother: Mm hmm.

Nurse: Okay, bring him into the room behind me, get his temperature and weight taken.

Merrow: Tell me how it works. You're the triage nurse, so that's--you're the first person the kid comes to see. What happens?

Nurse: Okay, well, we fill out the triage slips--you assess the child. If the child is seriously ill, we bring him immediately down the ramp. If it's a child like an asthmatic that you're going to need a temp and a weight on first, before they go, you take their temp and the weight, and then they go down the ramp. It's just a method of screening out children that are too ill to sit out and wait their turn. And once they get their temp and weight taken, they go in the booths; they get a route sheet, and the route sheet goes back in the nurse's station.

Merrow: This is really not an emergency room in the sense, maybe, that I used to think of it--everybody's got something seriously wrong. This is almost a family doctor--.

Nurse: Well, in a way you could--I guess you could think of it as that. But, um, we do, you know, we have our share of emergencies too. But, um, not every day is full of emergencies. There are days when every kid that comes in the door is sick, and then there is other days when, uh, we don't see a lot of seriously ill kids.

Merrow: Those two kids you were just checking in--they have colds apparently.

Nurse: Yeah. Well, we can't turn them away, you know, we have to see them. We see a lot of colds, and, uh, the number is decreasing now, because the cold season is decreasing. We see a lot of colds. Some of them turn out

to be pneumonia, some turn out to be a cold, you know.

Merrow: I just talked to one young woman who brought her child in, and she said that the child hadn't been playing the way she usually does. And that was really the main sign. Now, I said, "Did you take the child's temperature?" And she said, no, she hadn't. She thought she had a fever, but she hadn't. I wonder, is that common? I mean, a--a parent just kind of having a suspicion something is wrong, but--but not even knowing enough to take the temperature?

Nurse: Yeah. A lot of them don't know how to take the temperature. And that's one of the problems that we find. Some of them, you can--you can explain to them how to take a temperature, and they'll know the next time, if the kid feels warm that it doesn't mean that he has a temperature. But then a lot of them, they don't know how to take a temperature, and you try over and over again to explain it to them, and they still don't take the temperature. They go by their kid's skin feeling hot. If he's--we have this a lot of times in the winter--if a kid is bundled up in three blankets, he's going to be hot. And they'll come in, they'll say the child has a fever, and once you take the cover off and let them sit out in the air for 30 minutes, the temperature goes down. So it's, you know, one of the things we have to deal with, I guess.

Merrow: One of the things I hear from time to time is that poor people feel differently about their children than do people who are well off. Do you believe that?

Nurse: No. I don't believe that at all. I think some of them care just as much or more about their children than do well-off people. I think a lot of them get to spend more time with their children--some of them are home, they aren't working because they can't get anyone to mind the kids. A lot of them, I think, are much--feel much closer to their children. They have a different way of showing it, I think.

Merrow: What does that mean?

Nurse: Well, some are--I don't know how to explain it. Uh, some of them have a different way of showing it. I--I think they care as much. It's just, you know, they can't--a lot of them aren't able to, you know, like endow the child with a lot of physical, you know, things, because they just don't have the money. So it's shown in other ways, you know, the way they care for the child. I think just bringing the kid to the hospital every time he gets sick is really a way of saying, "Well, you know, I care about my child. I don't want, you know, any harm to come to him."

Reinhardt: Sharon Hawthorne, the screening nurse at Charity Hospital in New Orleans. The infant mortality rate at Charity is 15 1/2 deaths per thousand live births. That's nearly three times worse than at a nearby private hospital. But then, again, Charity tends to get more high-risk cases--for instance, pregnant women who are very young or who have had little prenatal care. Dr. Kathryn Knight, of the pediatric unit.

KNIGHT DISCUSSES THE QUALITY OF CARE AT CHARITY HOSPITAL

Knight: I think that we provide a real service to the community. I think that many patients come back here after being seen elsewhere, because they like the level of care that they receive.

Merrow: A hospital like this, and this hospital in particular, has a bad reputation, though. Why?

Knight: I don't think that it has a bad reputation. It depends on whether you're on the outside looking in, or whether you've actually been here and worked here. There are many people in the community who are critical, but many of them have never darkened the doors, or if they have, it's been only sporadically, and for, uh, a few visits. There are, like any other large institution, of course, problems, that are associated with moving large volumes of people in and out through a health care system. We handle extremely large numbers--much larger than you would find in most smaller community hospitals. But we do it with relative efficiency and with excellent medical care.

Merrow: Dr. Knight, is this a fair generalization about health care for the poor--they would be likely to come to a doctor or to a hospital much further along in the disease, or in the harmful condition--they wait longer.

Knight: That might be true if they had to pay for it. It is not true here. They come here with very minor illnesses, very early, looking for prophylactic care, or for notes to go back to school, or for just some advice to the mothers as regards infant care. They come here very early. We have extremely few patients, unless they live a large distance from the hospital, who postpone coming here for any reason at all.

Merrow: You're saying the poor are well served.

Knight: I believe they are.

Merrow: The poor are well served. The non-poor, the well-to-do are well served. They can buy whatever care they want. In your judgment then, who is not well served?

Knight: The middle class, who always seems to be caught in the middle. The family who has a modest income, who, uh, can afford to buy the necessities for their family, but cannot afford any of the luxuries, and who have only minimal hospital coverage, are devastated by large hospital bills, by lack of being qualified for complete total free care, such as we have at Charity, for having to buy prescription drugs--those people are caught in the--in the bind. There are many people who qualify for so many programs under the government auspices, that it is hard to distinguish poor from non-poor, because people who are considered indigent are able to buy for themselves and their families merchandise that is non-affordable by a large number of people who have reasonable incomes, but who are committed to other obligations.

Merrow: You mean, they are paying taxes, all that sort of thing.

Knight: Yes, that's what I mean.

Reinhardt: Dr. Kathyrn Knight, associate director of pediatrics. She's been at Charity Hospital since 1967. Poor people do have access to free or subsidized health care, but they sometimes make real trade-offs to get it.

CAB DRIVER TELLS WHY HE REMAINS AN UNMARRIED PARENT

Merrow: I'd like you to tell me about your baby, and where your baby was born, and how.

Cab driver: Okay, my baby was born in Public Health Hospital, it's in New Orleans, and the procedure was that my wife and I--I mean, the girl and I had a baby, and Public Health took care of the kid, the state of Louisiana supported all the expense, all the doctor bills, and in the future--in the future of my baby, as far as the feeding and the sheltering. And--.

Merrow: You started to say, "my wife." And then you said, "my girl." You're not married?

Cab driver: No, we're not married yet. We're planning on getting married. But right as now, we're not married.

Merrow: You could be married though, and you want to get married.

Cab driver: Yeah.

Merrow: Why aren't you?

Cab driver: Well, in--you know, before--before we had the kid, we was undecided on, you know, what we were going to do ourselves and, you know, what our goals were. But after our kid was born, you know, we seen a different light, and, you know, we want to, uh, we want our kid to grow up, you know, father-mother type of kids, you know.

Merrow: Okay, but if you were married, you'd be paying much more for that baby, right?

Cab driver: Yeah, unofficially I would. I would be paying more because if we were married, then the state would--would probably want to know my income and you know, by us being married it's two people, you know, totally committed to one child, where, when we had the baby at first, it was just her, and not me.

Merrow: Your wife quite her job a month before the baby was due, and you filed for eligibility, so you could basically have a free baby. You're beating the system.

Cab driver: Well, it's--it's--it's not beating the system, I don't think. It's--it's a thing where a lot of--lot of young couples get caught up, and the wife feel unsecure about, you know, the, you know, the amount of money that she would probably need to, you know, to have the baby

successfully. So she files for, um, for some sort of security, like INCS, like welfare and food stamps, and all, because--strictly because of the insecurity of the guy, because if she's not married, then the guy might feel like, you know, he's not really obligated to helping, you know, her. Which in my case, I was totally different, you know. I was willing at the time to help her as fully as I could. But as far as the doctor bills, I don't think I could afford them. No, no.

Merrow: And there is a way to get around them. By not being married she can go in and apply for the benefits, um, and get them for free.

Cab driver: True, she can go in and be pregnant and apply for, um, social welfare and all, and get it.

Merrow: Don't they investigate? Don't they say who is the father? Will the father help support the baby?

Cab driver: Sure. They--they--they called me! They asked me, they wanted to find out who I was, they wanted my wife to file--I mean, my girl to file, um, um, child support, which, that's what--my name was in the child support category, until I went down there willingly to take care of my baby and support her to my best ability, financially.

Merrow: So, are you doing that?

Cab driver: Yeah, I have to--the 20th of May will be my first installment to the state, towards helping my daughter.

Merrow: You're paying some money to the state?

Cab driver: Yeah, I pay some money to the state and they pay some money to the state.

Merrow: But the state is paying more to your girl and your baby than you are paying to the state.

Cab driver: Yeah, they are paying twice or more. Yeah, they're paying more.

Merrow: Your wife--your girl--could have said, "Oh, I don't know who the father is," or "He's gone," or something like that. Right?

Cab driver: Yeah, she could have said that, she could have said easily that "I don't know who the guy was--I had several guys." But in my case, she--she's a one-woman's man, and she just told them who I was, and I, like I say, I didn't regret it and I don't regret it now. It just came out to be, um, beneficial to my daughter and to my wife that she was eligible for, um, for the state to support her at the time of pregnancy and the delivery.

Merrow: In a way, the system is encouraging you to stay away from your woman and your baby. The system is encouraging not getting married--discouraging marriage.

Cab driver: Well, I don't know, you know. It depends. Like if people cannot afford to take on responsibility, then they're going to use any, you know, escapism they could to

get away from, you know, from losing the benefits. I think, sure, I think the state, the way it's set up, a person who cannot afford to support a child, more or less have to lie or, uh, tell them that they're not married and not get married until things got better for them in the future.

Merrow: A taxi driver in New Orleans. After we talked, I was left with the feeling that our system encourages poor people to behave the way we think poor people behave. We think they're irresponsible, so we ask them to be. Here's another example. A young girl who wants to leave her parents' house after a quarrel, but has no money. Pediatrician Jay Goldsmith.

GOLDSMITH DESCRIBES ANOTHER EXAMPLE

Goldsmith: One of the ways she can move out of this house, and it's been told to me many times, is that she goes and finds a boyfriend and she gets pregnant. Now that she's pregnant, she can go down to the AP--aid to family, dependent children's, to the welfare office, pick up her AFDC check, a couple hundred dollars a month. Now she's got some money to live away from her parents. So here, the government offers a stimulus. Or the other way is that the grandmother of the baby to be born is running out of money or times are tough, and she lets her daughter get pregnant--or encourages her to get pregnant--so that there is another extra $200 or some dollars coming in each month to that household, and it doesn't matter who--who is the father of the child. So really the whole social fabric of our society, of the family, is being looked at when we look at the--the idea of maternal child health in our country. And these are very, very deep issues which, happily, physicians are beginning to look at.

Merrow: But you can't argue on the one hand for providing better nutrition and better care, and then on the other hand tell me that if you do this it in some way encourages kids to go out and get pregnant. That is what you're saying.

Goldsmith: Yes, unfortunately it's a two-edged sword. On the other side of this same issue--if we stop federally-funded abortions, that will affect the poor population and the teen-aged poor person, and not the teen-aged rich person, because her parents are still going to pay for her abortion--she'll go somewhere to have it. So all of this politics really has to do with a very rich-poor kind of orientation.

Reinhardt: Pediatrician Jay Goldsmith, of Ochsner Clinic in New Orleans. Whatever the drawbacks in the present health care system, it's unlikely the situation will improve. Efforts to beat the system might increase as public health funds dry up and qualification requirements become stricter. President Reagan's budget proposal calls for reducing all federal health care programs by 25 percent. In 1982, that would cut one billion dollars from Medicaid alone.

Merrow: Reagan also wants to consolidate all health care programs, except Medicaid, into two block grants, letting the states decide how to spend the money. So far the House and Senate seem likely to go along. What will the cuts mean for poor kids' health care? Pediatrician Frederick Greene says each hospital will have to choose which kind of care to provide--tertiary care for the most seriously ill, or basic care, called primary and preventive care. Dr. Frederick Greene.

GREENE DESCRIBES THE ECONOMIC AND SOCIAL IMPACT OF BUDGET REDUCTIONS ON HEALTH CARE SERVICES

Greene: What services do you think we have to cut back when we have to tighten the belt? Well, it's the primary care--it's the preventive health care services. And so, it's like a--a domino thing. You cut back funds to save money in tertiary care, and sometimes that can't save money because the kids require care, and then that increases the deficits of the hospital, then the hospital has to cut back, and then we can't provide the primary care, and then there'll be more kids who will have untreated diseases, and then they will later require tertiary care. It's a vicious circle. And sooner or later somebody's going to get smart enough to understand that we have to invest in primary as well as tertiary care, and not make the health system within itself compete for funds--how much will go to--to open-heart surgery versus how much will go to immunizations. It's silly! We need them both.

Reinhardt: But who should pay? The state should pay? Who?

Greene: Well, um, Rene DuBois, up at Rockefeller Institute said something I remember, sort of in answer to that. He said it's a measure of society's concern for its children when it will tolerate the continued death and disability of children due to preventable diseases--and he was talking about lead poisoning then. Yeah, I think it's society's concern. I think parents have the responsibility, but if the parent is either unwilling or unable to provide the care for the child, I--I--I say it is society's--the general society's--responsibility to prevent the suffering of any child.

Reinhardt: Even unwilling?

Greene: Yes, yes. A child didn't ask to come here. A child is--is totally dependent upon the needs of adults, and if--if a parent is--cannot be a good parent, we usually, in the greater society, either suspend or terminate the parental rights and put the child in either residential care or--or have them--put them up for adoption. But in some way we--every society must care for its young. That's the future. And the degree to which we properly care for the young is going to be reflected in the kind of society we have in the future. So those of us here now--we're not going to be here always. A hundred years, most of us will be dead and gone. Our kids--and their kids--will be running this world, and hopefully it will be a better world because we have provided the kind of care, of compassion and concern for others, and brotherhood, and so on, that will make it a better world. I--unfortunately, I don't see

that concept being put to practical use at the present time. The poor are, uh, the cause of their plight--that's social Darwinism, I think you call it.

Merrow: Dr. Frederick Greene, associate director of Children's Hospital in Washington, D. C. Judy Weitz, of the Children's Defense Fund, is also worried about the Reagan proposals.

WEITZ SHARES HER CONCERNS REGARDING THE EFFECTS OF THE REAGAN BUDGET CUTS ON CHILDREN'S HEALTH CARE

Weitz: All the data shows that when you invest in prevention, you bring down health care costs. And you know, the studies show time and time again--I was just reading about a county in San Antonio, around San Antonio, Texas, where when the policies were changed so that access to the clinic, uh, was more severely limited, they got a 44 percent drop in clinic visits. And simultaneously they got a 21 percent increase in emergency room visits. Now emergency room visits, not only--probably most of those families weren't getting the care, or inappropriately going there for the care that they needed--but it's also two to three times as expensive as the clinic visits. So I don't think that when you take away an investment in prevention and primary care that you're going to bring down costs at all. You're going to pass them to another sector. You're going to pass them on to hospitals, you're going to pass them on to private insurance policies that have to pick up, um, the short fall in hospital financing. You're not going to lower costs at all.

Um, for instance, one of the things that they're doing in a lot of states is limiting the number of hospital days that Medicaid will pay for. One of the primary groups of people affected are babies who require intensive infant care. In Maryland, for instance now, they have a 20 day limit. They have found that three out of ten babies born in that state need more than that 20 days in the hospital--these are high-risk babies who need intensive care. What is happening is they are refusing to admit high-risk mothers, because they don't want to have to be stuck with the babies in the hospitals, and not be able to pull down reimbursement--Medicaid reimbursement--for those children, for the full length of their stay. That's the kind of thing that's happening.

You find that, uh, families are being asked to share in the cost of care. Now that sounds reasonable--$50, uh, 50 cents on a prescription, $3 on a physician visit. But when you consider that many of these families are living on $120, $140 a month, that they've got cuts in food stamps, cuts in their cash assistance, cuts in--in their housing subsidies, rising electrical bills, rising heating bills, and they have two or three children--and if their children are like my children, when they were very little, you know, they had to go in many times a year for ear infections, strep throat, well-child visits, eye examinations, physical exams to go to school, day-care camp, whatever--that $3 starts to mount up. The result is you don't take your child in. The result is, is a more severe condition, a sicker child. You go to the emergency ward, or the child

ends up in the hospital. More costs to everybody. Um, so that pattern is very much there.

The other thing that is happening is cutting out, um, actual categories of people who are eligible for services. One category we're particularly concerned about is the pregnant woman. In many states now, a woman who is pregnant for the first time can get Medicaid coverage for prenatal care. Those women are now being cut. They will not be able to get care until they have actually had the baby. That's kind of ironic. Um, again, if you are pursuing a preventive strategy, again, when the pressures to do this are going to be intensified by an administration that supposedly stands for prevention, and supposedly stands for protecting the life of the fetus, how do you reconcile the fact that one group of people who is going to be particularly hurt are pregnant women?

Merrow: How do you reconcile it? What's your explanation?

Weitz: I don't! I don't reconcile it, because it's irrational to me. I--I think that, um, a lot of the decisions that are being made are intensely political and have nothing to do with the--the really substantive policy issues at hand, that that's not the level at which they're being made.

Merrow: I don't understand what you just said.

Weitz: It's hard to explain! I think that perhaps the decision is being made because of a need to have the support of a particular constituent group--that is, the right wing, the pro-life forces, the evangelical lobby, whatever--behind the administration, and that that is the primary issue. And whether or not, um, that need for political support squares with substantive decisions that are being made in policy areas is not one that seems to be terribly troublesome to the administration in the area of health care.

Merrow: You said that some of these cuts are having perhaps unanticipated consequences. You mentioned a woman, a high risk pregnant mother being turned down at the hospital because of the Medicaid cap--20 days of service. What happens to that woman? Where does she have her baby?

Weitz: Sometimes they have them in parking lots--we know that's happening, um, in some parts of the country. Sometimes they will go to a hospital that receives what are called Hill-Burton funds, where they have to be admitted because of certain clauses in the law, um, which bind those hospitals to take them.

Merrow: Judy Weitz, of the Children's Defense Fund in Washington, D. C. What will happen? Well, those who are fighting Reagan's proposed cuts are not optimistic. Last year's Congress, then controlled by Democrats, refused to pass a bill that would have increased preventive services for poor children. This year's Congress is even more budget minded, and what they have in front of them to consider are cutbacks, not increases.

Reinhardt: If you'd like a copy of this four-part series,

just call this toll-free number: 800 253-0808, and ask for the OPTIONS IN EDUCATION series on Children's Health Care. Cassettes and transcripts are available; you can get the details over the phone. The number again is 800 253-0808. If you live in Michigan, call 616 471-3402.

Merrow: If you want to write to us directly, our address is National Public Radio--Education, Washington, D. C. 20036.

Reinhardt: OPTIONS IN EDUCATION is a co-production of National Public Radio and the Institute for Educational Leadership of the George Washington University. Support for the series is provided by the National Institute of Education and the Corporation for Public Broadcasting. John Merrow produces this series and Rebecca Goldfield is our associate producer. Our assistant producer is Alex Van Aus. Our engineers are Dennis Herndon and Greg Hedgepath. I'm Barbara Reinhardt.

Merrow: I'm John Merrow, and this is NPR--National Public Radio.